KENTUCKY MEDICAID PROGRAM ORTHODONTIC EVALUATION FORM

o.otaC	of Recor	ds/Examination		Date Received	······································
	Approv	/al	Disapproval	Total Treatment Fee	
1.	Patien A.	Guardian Address		Birthdate	
	B. C. D.	KY Medical Assista Chief Complaint Pertinent Medical a	nce Card Numbernd Dental History:	IP	

II.	Clinica	Examination:			
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J.	Radiog	raphic Examination:			

	Radiographic Examination:		
\/	Coat /	Analysis	
V.	Cast	Analysis:	
VI	Summ	nary:	
	A.	Prioritized Problem List:	
	B.	Treatment Plan:	
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